

**ONLINE PHYSICIAN
Only \$7.95 per month!**



ALLIANCE FOR SMALL BUSINESS

APPLICATION

ID# _____ (Office Use Only)

Effective Date:

Plan _____ (Office Use Only)

Last Name:		First Name:		SS#(last four)		Email:	
MI		City:		State:		Zip:	
Telephone:				Fax:			
Signature:						Date:	
Please indicate the website that referred you to us:							

Automatic Bank Withdrawal of \$7.95 per month

Please complete the form below and attach a voided check.

For Non Bank Draft Billing, send the completed application and 47.70 for a minium 6 month benefit period.

I hereby request and authorize Alliance For Small Business, Fort Worth, Texas, to initiate debit entries to my account indicated below. This authorization shall remain in effect until revoked by me in the manner provided by law. Until you receive such notice, I agree that Alliance For Small Business shall be fully protected in honoring any debit to my account.

Name:
Signature of Account Holder:

Dates of Withdrawal: 1st of the month
Date:

Attach Voided Check

www.allianceforsmallbusiness.com

Telephone: 817-732-6155 Fax: 817-377-9591

Alliance For Small Business
PO Box 101807
Fort Worth, TX 76185